Washington State
Department of Social
& Health Services

Report to the Legislature

EXPANDING COMMUNITY SERVICES: STATUS OF EFFORTS TO REDUCE THE STATE HOSPITAL CENSUS BY 178 BEDS BY APRIL 2003

Chapter 7, Laws of 2001, E2
Sections 204(1)(d), 204(2)(e), 206(6) and 206(7)
Uncodified

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EXECUTIVE SUMMARY

The 2001-2003 Operating Budget, Chapter 7, Laws of 2001, E2, Sections 204(1)(d), 204(2)(e), 206(6) and 206(7) uncodified, provides for the development and operation of community support services for state hospital patients with substantial barriers to community placement who no longer require active inpatient psychiatric treatment. In accordance with this proviso, the Department of Social and Health Services (DSHS) continues to implement the Expanding Community Services (ECS) Initiative.

Planning to implement the transition of long term state hospital patients to community support services is being conducted through the combined efforts of a number of DSHS entities and other partners. Individuals who will be transitioned currently reside on wards of the Adult Psychiatric Unit (APU), Gero-Medical Unit (GMU), and Program of Adaptive Living Support (PALS) of Western State Hospital (WSH) as well as the Gero-Psychiatric Unit (GPU) at Eastern State Hospital (ESH). The transitions are expected to take place in phases according to the following schedule:

Phase I: 30 patients from the WSH APU in December 2001 - complete
Phase II: 30 patients from the WSH APU in July 2002 - complete
Phase III: 30 patients from the WSH GMU in October 2002 - complete
Phase IIII: 28 patients from the ESH GPU in December 2002
Phase V: 30 patients from the WSH PALS in January 2003
Phase IV: 30 patients from the WSH GMU in April 2003

It is expected that development of new and enhanced programs and services in the community will allow for the reduction of a total of six wards at WSH and ESH concurrent with each of the phases.

An unforeseen event that affected the ECS Initiative was the February 2001 earthquake in western Washington. The earthquake damaged buildings and reduced capacity at WSH effectively resulting in a loss of 30 APU beds and 30 GMU beds. To sustain the reduced capacity, Regional Support Networks (RSNs) and community long term care providers have undertaken extraordinary efforts to maintain, in community settings, individuals who would otherwise have been served at WSH. As a result of these efforts, there were no additional transitions required in order to accomplish the first APU ward closure scheduled for December, 2001 or the first GMU ward closure scheduled for October 2002.

In addition, the transition community of 31 long term APU patients at WSH resulted in the ward closure scheduled for July 2002. These patients have been placed in a variety of intensive residential or community support programs in five of the western RSNs that submitted plans and contracted with the Mental Health Division (MHD). All but one of the patients returned to the RSN where they resided prior to hospitalization. Despite significant challenges resulting from their disabilities and long histories of hospitalization, most of these individuals are reported to have adjusted well to community integration and appear to be content with their current community placements.

Current efforts are underway to develop resources for patients scheduled to transition through remaining phases of the Initiative. The MHD has received plans and is negotiating contracts with seven western RSNs for the transition of long term PALS residents back to their communities. DSHS's Aging and Adult Services Administration (AASA) is negotiating contracts with providers for enhanced community long term care beds. These beds will be used to serve GMU/GPU patients transitioning from the state hospitals and to serve individuals struggling in current community settings at risk of hospitalization.

An implementation committee including representatives from various stakeholders has developed an Expanding Community Services(ECS) workplan and will monitor progress and make revisions as needed. Key activities which continue include:

- Identification and assessment of ECS patients
- Improvements in WSH discharge processes
- Development of a consumer preference survey
- Development of transition best practices guides
- Development of cross system teams (A-teams) to improve coordination of multiple needs clients
- Development of RSN plans for serving ECS patients
- Development of community long term care settings and mental health supports to provide care for GMU/GPU residents
- Training of County Designated Mental Health Professionals (CDMHPs) and update of CDMHP protocols to increase consistency in implementation of involuntary treatment laws
- Creation of new category of facility licensure more able to accommodate individuals with significant medical and behavioral needs
- Training for long term care facilities in accessing mental health and crisis services
- Ongoing research into other states' efforts at transitioning long term state hospital patients to community settings
- Communication with the Center for Medicaid and Medicare Services (CMS) to assure optimum utilization of federal funding
- Pursuit of other federal grants in support of the Initiative

- Evaluation of implementation with a final report completed by December, 2003

The department faces a number of challenges in moving forward with efforts to develop appropriate community services for long term state hospital patients. Primary challenges include community acceptance, access to community psychiatric inpatient resources, access to primary care physicians, resistance of family members to community placement, difficulty for residential providers in maintaining affordable insurance and a shortage of available skilled nursing facility beds in eastern Washington.

At the national and state level, there is continued pressure to assure that individuals residing in institutions have the option for community living. A recent study found that compared to a sample of peer states, Washington's length of stay for patients at the state hospitals tends to be longer due to the lack of community residential and intensive support resources. The ECS Initiative is moving to strengthen DSHS efforts to assure services are provided in the community whenever appropriate.

INTRODUCTION

The 2001-2003 Operating Budget, Chapter 7, Laws of 2001, E2, provides for funds to be used "solely for development and operation of community support services for persons whose treatment needs constitute substantial barriers to community placement and who no longer require active psychiatric treatment at an inpatient level of care, no longer meet the criteria for inpatient involuntary commitment, and who are clinically ready for discharge from a state psychiatric hospital." In addition, $1 million of the Mental Health Federal Block Grant (FBG) was designated to support the efforts of returning long term patients to their communities and reducing the use of state and local hospitals for short term crisis stabilization services.

Primary responsibility for this effort was placed with the Department of Social and Health Services (DSHS) Mental Health Division (MHD) and the RSNs. In addition, the Aging and Adult Services Administration (AASA) was directed to coordinate with and actively support the efforts of the MHD and the RSNs to provide stable living arrangements for long term patients with dementia and traumatic brain injuries. AASA was also directed to develop and implement strategies to reduce the use of state and local hospitals for short-term stabilization of individuals with these conditions.

This is the second report providing an update on the status of these efforts as required in current law.

BACKGROUND AND INITIATIVE GOALS

State hospitals were originally created to provide indefinite care for individuals with severe and persistent mental illness. With the advent of medications and more effective treatment approaches, individuals with severe mental illness are more able to manage their symptoms and live in their communities. As a result, the primary function of state hospitals has changed from providing indefinite care to providing inpatient psychiatric hospital treatment for individuals who have been involuntarily committed by a court in order to stabilize their conditions and assist with the return to their communities. Chapter 71.05 RCW establishes legislative intent to "prevent inappropriate, indefinite commitment of mentally disordered persons" and directs "whenever appropriate, that services should be provided in the community."

At the national and state level, there is continued pressure to assure that individuals residing in institutions have the option for community living. These efforts have been highlighted through litigation such as the Olmstead lawsuit in Georgia where the Supreme Court found that the state was violating the rights of two plaintiffs by keeping them in a state psychiatric hospital despite their desire to live in the community. In Washington State, lawsuits alleging that patients with developmental disabilities need better care and coordination leading to

community placement have resulted in settlements at both of the state hospitals. In addition, Washington has been threatened with the loss of federal funding for state hospital patients who no longer require inpatient psychiatric treatment.

In January 2001, DSHS conducted a review of patients at the Adult Psychiatric Unit (APU), Program of Adaptive Living Support (PALS), and Gero-Medical (GMU) wards of Western State Hospital (WSH) and the Gero-Psychiatric wards at Eastern State Hospital (ESH) to assess the level of care needed by these patients. The review concluded that there are long-term patients who remain at WSH and ESH because of barriers to community placement. A recent study confirmed that compared to a sample of peer states, Washington's length of stay for patients at the state hospitals tends to be longer due to the lack of community residential and intensive support resources.

The Expanding Community Services (ECS) Initiative is currently being implemented to create appropriate community options for these patients. Through the combined efforts of a number of DSHS programs and community partners, the goal of the Initiative is to transition 178 long-term patients into appropriate community settings and programs. The transitions are expected to take place in phases according to the following schedule:

Phase I: 30 patients from the WSH APU in December 2001 - complete
Phase II: 30 patients from the WSH APU in July 2002 - complete
Phase III: 30 patients from the WSH GMU in October 2002 - complete
Phase IIII: 28 patients from the ESH GPU in December 2002
Phase V: 30 patients from the WSH PALS in January 2003
Phase IV: 30 patients from the WSH GMU in April 2003

Upon the transition of patients after each phase, a ward will be closed at the state hospitals. Provisions for the reduction of RSN allocated bed capacity at state hospitals have been written into the Washington Administrative Code and into contracts with the RSNs.

One unforeseen event that ultimately affected the ECS Initiative was the February 2001 Nisqually earthquake in western Washington. Several WSH buildings were damaged by the earthquake and could no longer be safely used for the care of patients. This resulted in an ongoing loss of capacity of approximately 30 APU beds and 30 GMU beds.

In order to maintain the reduced capacity created by the earthquake, RSNs and community providers undertook extraordinary efforts to develop alternative placements and diversions for patients and individuals that would otherwise have been served at WSH. As a result of these efforts, there were no additional ECS transitions required in order to accomplish the first WSH APU ward closure scheduled for December 2001 or the first WSH GMU ward closure scheduled for October 2002.

GENERL OVERVIEW OF IMPLEMENTATION EFFORTS

An Implementation Committee was formed to oversee Initiative efforts. The committee includes representatives from the following entities[1]:

- DSHS Mental Health Division
- DSHS Division of Alcohol and Substance Abuse (DASA)
- DSHS Aging and Adult Services Administration
- Department of Health
- Urban and Rural Regional Support Networks
- Mental Health Providers
- Residential Providers
- Consumer and Family Members
- Community Psychiatric Inpatient Hospitals

The committee has developed an implementation work plan and will remain active through the biennium to monitor progress and revise the plan as needed.

The ESC Implementation Committee quickly recognized the need to identify patients with barriers to placement and to make improvements in state hospital and community coordination efforts. Following is a summary of results of severalefforts to identify individuals with barriers to community living and improve coordination of services to these populations:

A: Identification of ECS Patients

A tool was developed to identify state hospital patients with significant barriers to discharge who are eligible for placement in enhanced resources created with ECS community funding. Screening at the hospitals has been completed and a pool of patients eligible for placement into the enhanced resources has been identified.

B. Improvements in Discharge Processes

An ongoing effort to address discharge barriers at WSH began in 2001. A number of systemic discharge barriers were identified. Improvements have been made on a number of these issues including:

- Improvements in the process for coordinating comprehensive assessments for patients requiring placement to a long term care setting
- Development of hospital discharge criteria reflecting input from community providers
- Improvements in coordination of discharge planning efforts between WSH treatment team and the community mental health system

[1] A full list of Implementation Committee Members is attached as appendix A

- Improvements in the information transferred from WSH to community providers for ECS patients with significant barriers to community placement[2]

C. Transition Best Practices Guide

Individuals who will be transitioned as part of this Initiative have been long term residents at the state hospital and will face multiple challenges in adjusting to community living. Guidelines for transition were developed to assist with the transition of these patients into community settings.[3]

D. Coordination of Cross System Services

A successful approach to coordinating the services of high risk multi-needs clients was developed in Snohomish County. This effort, called the A-Team, provides regular staffing for individuals with multiple disabilities by local representatives of the following systems:

- AASA
- Area Agencies on Aging
- Division of Developmental Disabilities (DDD)
- RSNs
- County Designated Mental Health Professionals (CDMHP)
- Mental Health Providers
- DASA
- Department of Corrections
- Law Enforcement

A-Team staffings have resulted in increased coordination of services and braided funding in order to meet the comprehensive needs of high risk clients. DSHS has worked to replicate the A-Teams throughout each of the DSHS regions. There are now active A-teams in the following counties:

- Pierce
- Snohomish
- Chelan
- Benton
- Whatcom
- King
- Clark

E. County Designated Mental Health Professionals Training

The successful transition of long term patients from the state hospital to community settings is only one component needed to accomplish reduction of beds at the state hospital. Efforts must also focus on improving the community's

[2] Nursing discharge assessment forms are attached as Appendix B.
[3] Transition Guidelines for APU/PALS patients and guidelines for GMU/GPU patients are attached as appendix C.

ability to successfully manage individuals in crisis and appropriately detain individuals in community settings.

CDMHPs play a major role in the implementation of the Involuntary Treatment Act (ITA) for both adults (Chapter 71.05 RCW) and children (Chapter 71.34 RCW). In order to assure appropriate utilization of the state hospital and to assure public safety, it is important that these professionals are well trained and that there are consistent protocols which reflect the dynamics of different populations and systems.

In order to address this need, MHD contracted with the Washington Institute for Mental Illness Research and Training (WIMIRT) to develop and implement a training curriculum. In June 2002, training on the ITA and allied systems including Mental Health, the Children's Administration (CA), DDD, and AASA was provided to CDMHPs. Another round of training will be offered in November 2002.

In addition to the CDMHP training, statewide CDMHP protocols were updated in September 2002. The review and update of these protocols also involved allied systems including Mental Health, CA, DDD, AASA, and DASA.

F. Licensure

Individuals with significant medical and behavioral issues often face challenges in being maintained in current long term care settings as a result of licensing standards. Interventions effective in managing difficult behaviors come into conflict with a resident's legal rights in these settings.

DSHS and the Department of Health (DOH) have developed an interagency agreement which will create a new category of facility licensed by DOH to accommodate these individuals. Regulations for the new type of setting have been drafted and are expected to be adopted by the end of this year.

G. Research; Programs in Other States

The department has contacted at least eleven other states to ascertain the level and type of community support for patients being discharged from state psychiatric hospitals. Two states were visited: Arizona, in conjunction with a planned visit for another reason, and Oregon.

Many states have specific programs for the rehabilitation of cognitively and functionally intact mental health patients back into the community. However, very few have programs designed to provide services for the cognitively impaired, functionally needy, medically complex individuals who also have behaviors that have caused them to be unsuccessful in long-term care settings in

the past. DSHS is working to incorporate elements of the few existing programs in efforts to develop enhanced resources for this population.

H. Federal Funding

Representatives from MHD and AASA met with representatives from the Center for Medicaid and Medicare Services (CMS) to provide information on the ECS Initiative and discuss federal funding issues. Communication with CMS will be ongoing to assure that ECS implementation can maximize the utilization of federal funding.

In addition to Medicaid matching funds being used to support the ECS Initiative, DSHS has received two grants from CMS that are being used to support the ECS Initiative. In August 2001, MHD received a $30,000 grant to provide training to Skilled Nursing Facilities, Boarding Homes, and Adult Family Home (AFH) providers. The training was structured to avert psychiatric hospitalization of individuals with dementia, traumatic brain injuries, and other long-term care residents through improved utilization of mental health services, crisis systems, and local resources.

In September 2002, DSHS was awarded a $1.3 million CMS Real Choice Systems Change Grant for a joint proposal between AASA, MHD, and DDD. This grant funding is intended to assist states in making system changes which will allow individuals with disabilities to live in the most integrated community setting appropriate to their individual support requirements and their preferences. A portion of the funding from this grant will be used to support objectives of the ECS Initiative including:

- Improvements in coordination between systems to facilitate the return of long term state hospital patients into appropriate community settings
- Improvements in coordination between systems to prevent unnecessary hospitalizations for individuals in community settings
- Expansion and evaluation of cross system staffing models (e.g. A-Teams)
- Conferences focusing on improving long term care options which include consumers, advocates, family members, service providers and staff from each of the department's major long-term care programs

In addition to utilizing Medicaid and CMS grant funding, DSHS is working to maximize the use of Medicare funding in support of individuals with dementia in long term care settings. Representatives from the department are engaged in conversations with CMS to clarify policies regarding the use of Medicare in these settings.

I. Communication Efforts

Along with the formal implementation committee and workgroups, DSHS is providing information, when requested, to interested stakeholders regarding ECS activities and providing the opportunity for input into planning. Communication activities include:

- Individual meetings with RSNs
- Updates for RSNs at statewide forums
- Updates for the Washington Community Mental Health Council Providers
- Updates for long term care provider associations
- Updates for consumer and family member groups
- Updates for the community psychiatric inpatient provider association
- Updates for the State Council on Aging

J. Consumer Preference Survey and ECS Evaluation

A consumer preference survey at WSH was conducted to gather information on the housing and service preferences of long term state hospital patients. The survey information is being shared with RSNs to assist in ongoing efforts to develop services which meet the needs and preferences of consumers.[4]

An evaluation of the ECS Initiative is being conducted by the Washington Institute for Mental Illness Research and Training. The evaluation will focus on the success of ECS implementation related to the following criteria:

- Provision of services in the least restrictive setting possible
- Prevention of unnecessary or lengthy hospitalizations
- Increase in community support/transition services
- Improvement in quality of life for consumers
- Cost savings to DSHS
- Improved placement and diversion alternatives

Evaluation status reports will be completed January 2003, August 2003, and December 2003. A final report will be completed by March 2004.

STATUS OF ECS TRANSITION EFFORTS

A: Phase 1- December 2001 WSH APU Ward

The APU wards at WSH primarily serve adults with chronic mental illnesses such as schizophrenia and bipolar disorder. The APU includes 2 admission wards which provide initial stabilization of patients. Many individuals are able to transition quickly to the community after a brief stay at the APU admission wards. Those who cannot be stabilized quickly are transferred to other APU wards which

[4] An executive summary of the survey is attached as appendix D.

serve patients needing longer term hospital care.

As discussed earlier in the report, there was a reduction in the capacity of WSH as a result of damage sustained by the Nisqually earthquake. RSNs have worked hard to provide alternative community placements for patients and some individuals who would otherwise have been served at WSH. Deciding it would be inefficient to open a new ward to get back to capacity prior to the earthquake simply to close it again through the first round of ECS transitions, the department considered the transition of patients planned for in December 2001 completed as a result of the earthquake. The workforce at WSH was reduced and ECS community funds were provided to the nine western RSNs to reflect these efforts. RSNs are using Phase 1 ECS funding for a variety of local needs which are helping to maintain the reduced capacity at WSH including:

- Support of individual plans for transitioning current or past WSH patients with extensive length of stay and barriers to placement
- Enhancement of local crisis respite/hospital diversion efforts
- Strengthening and enhancement of local intensive case management and assertive community treatment programs
- Enhancement of discharge planning and coordination efforts at WSH
- Development of a part-time jail liaison position for intervention services to prevent need for hospitalization
- Provision of transitional residential services for individuals leaving the hospital or at risk of hospitalization
- Prevention or minimization of hospitalizations of some long term patients through specialized models for high utilizers
- Support of ECS planning, resource development, and transition efforts including completion of a local residential services evaluation
- Enhancements for a local co-occurring disorders housing support program providing transitional housing for consumers discharged from WSH, homeless, or at high risk of hospitalization
- Provision of expanded community inpatient services for individuals living in the community who are in need of hospitalization

B: Phase 2- July 2002 WSH APU Ward

In accordance with Chapter 7, Laws 2001, E2, Sec. 204(1)(c), plans for serving Phase 2 ECS identified WSH APU patients were requested from the RSNs in November 2001 and evaluated and approved in January 2002. Guidelines for the use of ECS funding were provided in accordance with the budget proviso. Six of the nine western RSNs responded to the request for plans, however, one later withdrew their plan. RSN plans were required to address how they will meet the comprehensive needs of these patients including residential and housing supports, coordination of medical care, and co-occurring substance abuse disorders.

MHD contracted with the remaining 5 RSNs for the development of 30 enhanced community slots for WSH ECS patients by July 2002. The RSNs and breakdown of slots are as follows:

RSN	Slots Requested	Slots Allocated
North Sound RSN (Includes Whatcom, Skagit, Snohomish, San Juan, and Island Counties)	13	13
Peninsula RSN (Includes Clallum, Jefferson, and Kitsap Counties)	7	7
Thurston Mason RSN (Includes Thurston and Mason Counties)	7	7
Clark RSN (Clark County)	3	3
Timberlands RSN (Includes Pacific, Lewis, and Wahkiakum Counties)	1	1
Total Slots	30	30

The RSN contracts require that the RSNs transition and maintain a minimum of 30 ECS identified patients in their communities from July 2002 throughout the remainder of the biennium. In cases where an individual needs to return to WSH for clinical reasons or leaves the region, the RSN can use the community resource to serve another ECS identified individual.

The majority of the patients identified for transition by July had very long term histories at the state hospital. Statistics regarding recent and cumulative length of stay at WSH reveal:

- Close to 80 percent of these patients had been continuously at WSH over a year prior to their ECS discharge
- Approximately 40 percent had recent stays ranging from 2-14 years.
- Of the 20 percent whose last stay was less than 1 year, all have had multiple admissions to WSH with their average cumulative length of stay at WSH in excess of 3 years.
- Approximately 75 percent of the individuals identified for transition have cumulative stays at WSH in excess of 2 years.
- Over half have cumulative stays of over 3 years.
- One third of the individuals have cumulative histories in excess of 5 years.
- Five of the patients have cumulative histories ranging from 10 – 25 years.

Aside from their long histories at WSH, these patients all had a number of identified barriers to community placement. Common themes of barriers identified for all of these individuals include:

- Histories of failed placement attempts
- Histories of being denied placement by community settings
- Significant psychiatric symptoms and behavioral issues creating challenges in being served in community settings

In addition, a number of these individuals faced challenges resulting from medical, substance abuse, and community resistance issues.

Upon completion of the contracts with the five participating RSNs, assessments were completed and individual community care plans were developed for these 30 patients. A national consultant with expertise in developing community support plans for long term state hospital patients was contracted to support the RSN and community mental health providers in their staffing and transition of these patients.

The five RSNs were successful in transitioning 31 ECS identified patients into the community by July 2002. In order to meet budget timeframes, the RSNs began transitioning most of these individuals in May and June 2002 utilizing existing RSN funding to support the placements. ECS community funding became available to maintain these placements in July 2002.

All but one of the patients returned to the RSN where they resided prior to hospitalization. The remaining patient, a Clark County resident, was placed in Pierce County at the request of the patient and his guardian who resides in Pierce County.

The RSNs have utilized various approaches for supporting these individuals ranging from intensive residential treatment programs to intensive supported living models based on the needs and preferences of the individuals and the availability of community resources. Some of the individuals have moved from their original placement to a new setting better suited to meet their needs. Despite significant challenges resulting from their disabilities and long histories of hospitalization, most of these individuals are reported to have adjusted well to community integration and appear to be content with their current community placements.[5]

Reports indicate that only two of the individuals transitioned have returned to WSH. One of these individuals was quickly re-stabilized and transitioned back to his community placement. One is working toward re-stabilizing and is expected to return to his community placement within the next 2-4 weeks. A few of the

[5] A more detailed report of the placement and status of the 30 patients is provided as appendix E.

individuals have required brief stays at community psychiatric hospitals and have returned to their community placements.

One of the individuals transitioning into the enhanced resources has passed away from a complicated and rare medical condition which was contracted in the community. This individual was connected with good medical care and was doing well and reported being very happy in his community placement prior to becoming ill. The community slot vacated by this individual was filled by another ECS identified patient from this community.

C: Phase 3- October 2002 WSH GMU Ward

The GMU wards at WSH and GPU at ESH primarily serve older adults with mental illness or adults with co-occurring medical and behavioral disorders. Many of these patients suffer from dementia or other organic disorders who came to WSH from skilled nursing facilities and other long term care settings with little or no history of community mental health treatment. As a result of their conditions, many of these patients can become assaultive to caregivers requiring enhanced staffing levels and staff training for successful community placement.

Like the APU, the GMU/GPU includes admission ward beds which provide initial stabilization of patients. Many individuals are able to transition quickly to the community after a brief stay at the GMU/GPU admission wards. Those who cannot be stabilized quickly are transferred to other GMU/GPU wards which serve patients needing longer term hospital care.

Similar to Phase 1, the reduction in the capacity of WSH as a result of damage sustained by the Nisqually earthquake resulted in pressure on community providers to serve and maintain individuals with co-occurring medical and behavioral issues who otherwise would have been served at WSH. The decision again was made that it would be inefficient to re-open a GMU ward simply to close it again in accordance with ECS goals. Therefore, the Department considers the transition of patients planned for in October 2002 completed as a result of the earthquake. The workforce at WSH was reduced and ECS community funds are being utilized to develop enhanced community resources for individuals with co-occurring medical and behavioral disorders as detailed below.

D: Phase 4 and 6- December 2002 ESH GPU Ward and April 2003 WSH GMU Ward

Throughout meetings with the ECS Implementation Committee, RSNs, and AASA, it became clear that the majority of GMU/GPU patients to be transitioned as part of ECS would require a skilled nursing facility or other enhanced long term care setting. As most RSNs have little or no experience in developing skilled nursing resources, it was agreed that AASA would take the lead in the

development of resources for serving ECS GMU/GPU patients. A memorandum of understanding is being developed to allow the community funding for all ECS GMU/GPU phases to be transferred from MHD to AASA who will contract for the resources to serve this population.

Another factor which became clear throughout these meetings is that for every patient to be discharged from the GMU/GPU, there are a greater number of individuals struggling in community long term care settings who without additional supports would quickly fill these hospital beds. In order to meet the goals of the legislature to transition long term patients and reduce state hospital beds, AASA plans to combine ECS community funding with skilled nursing facility and Community Options Program Entry System (COPES) funding for which these patients will be eligible.

In utilizing existing funding, AASA will be able to develop approximately 160 enhanced community resources for individuals with co-occurring medical and behavioral disorders. These resources will provide both an enhanced rate for residential providers allowing for enhanced staffing patterns as well as a package of mental health supports designed to meet the challenging behaviors of this population. Of the 160 enhanced community beds, a minimum of 58 will be used to serve ECS identified GMU/GPU patients. The remainder will be used to serve other hospital patients or individuals in community settings at risk of hospitalization.

The identification of the residential and mental health providers who will be contracted with to serve these individuals is being done at the local level by AASA and RSN staff and is expected to be completed in October 2002. Contracts are currently being negotiated. The department expects that resources in Eastern Washington will be operational in November 2002 allowing for the transition of 28 ESH GPU patients by December 2002. The department expects that the resources in Western Washington will be operational in January 2003 allowing for the transition of 30 WSH GMU patients by April 2003.

E: Phase 5- January 2003 WSH PALS

Similar to the APU, PALS wards at WSH primarily serve adults with chronic mental illnesses such as schizophrenia and bipolar disorder. PALS is a community transition program for individuals who no longer require a hospital level of care but need additional effort to prepare them for a residential or independent community placement. Barriers to placement for ECS PALS patients are identical to APU patients including:

- Histories of failed placement attempts
- Histories of being denied placement by community settings
- Significant psychiatric symptoms and behavioral issues creating challenges in being served in community settings

- challenges resulting from medical, substance abuse, and community resistance issues

As per the Phase 2 transition of APU patients at WSH, the MHD requested plans from the RSNs to serve ECS identified PALS residents through 30 funded enhanced community slots. Guidelines for the use of ECS community funding were provided in accordance with the budget proviso.

Seven of the nine western RSNs responded to the request for plans and asked for a greater number of community funded slots than is budgeted. The MHD has notified the RSNs of the tentative allocation of ECS slots contingent upon contract negotiations now underway. The breakdown of RSNs, slots requested, and slots tentatively allocated are as follows:

RSN	Slots Requested	Slots Tentatively Allocated
King RSN (King County)	15	14
Pierce RSN (Pierce County)	10	9
North Sound RSN (Includes Whatcom, Skagit, Snohomish, San Juan, and Island Counties)	5	3
Southwest RSN (Cowlitz County)	3	1
Clark RSN (Clark County)	2	1
Peninsula RSN (Includes Clallum, Jefferson, and Kitsap Counties)	1	1
Timberlands RSN (Includes Pacific, Lewis, and Wahkiakum Counties)	1	1
Total Slots	37	30

The department expects to finalize contracts with RSNs in October 2002 so that the transition of 30 ECS PALS residents can be completed by January 2003.

STATUS OF FEDERAL BLOCK GRANT FUNDING EXPENDITURES

In addition to the funds provided for development and operation of community support services for ECS state hospital patients, the legislature directed that $1 million of the Mental Health Federal Block Grant (FBG) was designated to

support the efforts of returning long term patients to their communities and reducing the use of state and local hospitals through:

- Initial development, training, and operation of community support teams which will work with long-term state hospital residents prior and subsequent to their return to the community
- Development of support strategies which will reduce the unnecessary and excessive use of state and local hospitals for short-term crisis stabilization services

To date, approximately $677,000 has been contracted in support of ECS efforts. The remaining $323,000 will be contracted by November 2002 in support of the remaining phases of the Initiative. Following is a breakdown on the funding which has been contracted to date:

Use of Funding	Amount
Provided to RSNs in support of plans to transition and maintain long term patients in community settings	$438,100
Used to hire a national consultant to assist with the development of individual community support plans for long term patients and to provide statewide training on developing effective crisis plans	$15,000
Used to co-fund a pharmacy residency program that will provide education on medications to patients discharged from the GMU/GPU and their caregivers	$42,700
Used to fund an evaluation of the clinical and cost outcomes resulting from the transition of long term state hospital patients into the community	$180,000

POTENTIAL CHALLENGES

As DSHS continues to implement ECS, there are some issues which continue to present potential challenges. Identified issues include the following:

- Community acceptance of some individuals being served because of their histories of challenging behaviors
- Access to community psychiatric inpatient resources
- Access to primary care physicians willing to provide for the medical needs of individuals with challenging behaviors
- Resistance of family members to community placement
- Difficulty for residential providers in maintaining affordable insurance

- Shortage of available skilled nursing facility beds in eastern Washington

CONCLUSION

The department is committed to serving individuals in community settings whenever it is appropriate and their needs can be safely met. At the national and state level, there is continued pressure to assure individuals residing in institutions have the option for community living. In accordance with national and state trends, the ECS Initiative is working to strengthen DSHS efforts to assure services are provided in the community whenever appropriate.

Despite fears articulated by advocates, the majority of individuals who have currently transitioned into the community through this Initiative appear to be doing very well and are generally happy with their community placements. Continued success of this Initiative will result in significant taxpayer savings as the cost of serving these individuals in community settings is less than maintaining them in high cost state hospital beds. However, the real victory will be the return of long term patients to their communities through highly individualized and supportive plans tailored to their needs and preferences.

APPENDICES

EXPANDING COMMUNITY SERVICES (ECS)
IMPLEMENTATION COMMITTEE
UPDATED 10/8/2002

Representing	Name	Phone/Fax	E-mail
Colby House-Geriatric Provider	Sue Closser Sunrise Services PO Box 2558 Everett, WA 98203	(425) 347-3149 FAX (425) 347-0492	sclosser@ix.netcom.com
ARRC	David Larsen Greater Lakes Mental Health Center 9330 59th Avenue SW Lakewood, WA 98499-6600	(253) 620-5740 FAX (253) 581-2540	davidc@glmhc.org
Geriatric Consumer/Family Representative	Arlene Engels PO Box 250 Sequim, WA 98382	PH (360) 683-3496	aengel@olympus.net
APU Consumer/Family Representative	Nancy Braswell Dispute Resolution Center PO Box 555 Bremerton WA 98337	PH (360) 377-4225 or PH (360) 377-8174 FAX (360) 377-7305	drcbridgesp@aol.com
Urban RSN	Stephen Greene Pierce County RSN 215 S. 36th Street Tacoma, WA 98418	(253) 798-4926 FAX (253) 798-4470	sgreene@co.pierce.wa.us
Urban RSN	Margaret Smith King County RSN Exchange Building 821 Second Avenue, Suite 610 Seattle, WA 98104	(206) 296-5213 FAX (206) 296-0583	Margaret.Smith@METROKC.GOV
DOH	Barb Runyon Facilities & Services Licensing Department of Health P.O. Box 47852 Olympia, WA 98504-7852	(360) 705-6620 FAX (360) 705-6654	Barbara.Runyon@DOH.WA.GOV
Western State Hospital	Jon D. Davis WSH-APU Administration 9601 Steilacoom Blvd SW, 18-305 M/S W27-19 Tacoma, WA 98498	(253) 756-2357 FAX (253) 756-3954	davisjd@dshs.wa.gov
Evaluator	Judy Hall DSHS/Mental Health Division PO Box 45320 Olympia, WA 98504-5320	PH (360) 902-0874 FAX (360) 902-7691	HallJJ@dshs.wa.gov

AASA HCS	Rick Bacon, Assistant Director Home & Community Services PO Box 45600 Olympia, WA 98504-5600	PH (360) 725-2321 FAX (360) 407-7582	BaconRJ@dshs.wa.gov
AASA HCS	Sarah Bacica Region 5, Home and Community Services Div. Mailstop N66-2 Tacoma, WA	(253) 476-7236 FAX (253) 597-4161	BacicSJ@dshs.wa.gov
AASA RCS	Jake Romo Home and Community Services PO Box 45600 Olympia, WA 98504-5600	(360) 725-2582 FAX (360) 438-7903	RomoJ@dshs.wa.gov
AASA RCS	Rosemary Biggins Residential Care Services PO Box 45600 Olympia, WA 98504-5600	(360) 725-2489 FAX (360) 438-7903	Biggire@dshs.wa.gov
DASA	Glenn Baldwin, Office of Planning, Policy & Legislative Relations Division of Alcohol & Substance Abuse PO Box 45330 Olympia, WA 98504-5330	PH (360) 438-8229 FAX (360) 438-8078	baldwga@dshs.wa.gov
MAA	Susan Fleskes Medical Assistance PO Box 45506 Olympia, WA 98504-5506	(360) 725-1565 FAX (360) 664-3884	FLESKSM@dshs.wa.gov
MHD	Paul Montgomery Mental Health Division PO Box 45320 Olympia, WA 98504-5320	(360) 902-0864 FAX (360) 902-7691	Montgpr@dshs.wa.gov
MHD	Andy Toulon Mental Health Division PO Box 45320 Olympia, WA 98504-5320	(360) 902-0818 FAX (360) 902-7691	touloan@dshs.wa.gov
Community Inpatient Hospital Association	Pam Sagoian		Pam.Sagoian@ArdentHealth.com
ESH	Anita Cornell Social Work Director Eastern State Hospital Medical Lake, Washington	(509) 299-7031	cornelan@dshs.wa.gov
Spokane Mental Health	Jenny Purcell, ARNP, 107 S. Division Street Spokane, WA 99202-1586	(509) 838-4651	jpurcell@smhca.org
Greater Columbia RSN	Robert Duckmanton, GCBH 101 N. Edison Street Kennewick, WA 98336-1958	(509) 735-8681	robertd@gcbh.org

Spokane RSN	Theresa Wright Monroe Court Bldg - 901 N. Monroe Street, Suite 328 Spokane, WA 99201-2148	(509) 477-5722	Twright@spokanecounty.org
Comprehensive Mental Health	Rick Weaver 402 S. Fourth Avenue Yakima, WA 98902-3546	(509) 575-4024	rweaver@cwcmh.org

Expanded Community Services
GMU/GPU Nursing Discharge Assessment Form

September 30, 2002

This form must be completed at least 7 days before discharge of an ECS patient. In order to assist in the successful placement of patients with significant barriers to discharge, please fill out this form as completely as possible. This form will be used to orient the staff of the receiving facility. It will additionally identify accommodations that need to be made for the patient to improve success in community placement.

Patient Name: _____

Name and Title of person completing form: _____

24° Nursing Contact _____ 7-3
(Name & Phone #)
_____ 3-11
(Name & Phone #)
_____ 11-7
(Name & Phone #)

Social Worker _____

Psychiatrist _____

Aggressive Behaviors: Check (✓) only if this is a problem area. Provide detailed information regarding past and recent aggressive behaviors. Please identify the severity of these issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
❑ Assaultive behaviors ❑ Threatens physical abuse ❑ Verbal abuse ❑ Impulse control ❑ Hostile/angry ❑ Suicide history ❑ Homicidal ideation/behavior/ history ❑ Property damage ❑ Self mutilation or other harm to self ❑ Arson ❑ Unsafe fire practices ❑ Legal history ❑ Assaults with objects ❑ (w/c, cane, etc.) ❑ Other behaviors which are a danger to self or others: _____ _____		

Interpersonal Skills & Cohabitation Issues: Check (✓) only if this is a problem area. Provide detailed information regarding challenges with interpersonal skills or behaviors that provide challenges for living with others. Please identify the severity of these issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
❑ Rummaging through/taking others belongings ❑ Takes others food ❑ Sexual acting out ❑ Preying on vulnerable others ❑ Exposing or disrobing in public ❑ Victimized by others ❑ Combativeness during personal care ❑ Feces smearing/playing/throwing ❑ Periods of screaming or inconsolability ❑ Intrusive ❑ Refusing bathing ❑ Non-responsive to emergencies ❑ Throws food/trays/objects ❑ Wandering ❑ Exit seeking ❑ Paces/runs ❑ Moves furniture ❑ Climbs on tables/chairs ❑ Other _____		

Mental Status Issues: Check (✓) only if this is a problem area. Provide information that may be helpful in addition to the diagnosis and medication lists that are provided. Please identify the severity of these issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
❑ Impaired judgement ❑ Memory impairment ❑ Confused ❑ Hallucinations ❑ Delusions ❑ Expressive aphasia ❑ Receptive aphasia ❑ Communication issues ❑ Mute ❑ Unable to follow directions ❑ Other _____		

Issues Related to Mood: Check (✓) only if this is a problem area. Provide information that may be helpful in addition to the diagnosis and medication lists that are provided. Please identify the severity of these

issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
❑ Depression/sadness ❑ Withdrawn ❑ Cries frequently ❑ Gets loud/yells ❑ Mood lability ❑ Easily agitated ❑ Anxiety ❑ Fearful ❑ Reaction to stress ❑ Hits wall/objects ❑ Other _____		

Functional Abilities, Supports/Nursing Issues: Check (✓) only if this is a problem area. Provide detailed information regarding functional abilities that provide challenges. Identify the severity of these issues, specific examples, and strategies for successfully accommodating or managing these issues.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
TOILETING ❑ Incontinent bowel ❑ Incontinent bladder ❑ Needs staff assist ❑ Frequent UTIs ❑ Frequent constipation ❑ Frightened of falling when toileted ❑ Other _____ AMBULATION ❑ Unsteady gait ❑ Uses assistive device ❑ Non-ambulatory ❑ Uses wheelchair ❑ Needs alarm on chair/bed ❑ Requires low bed ❑ Gets out of wheelchair unless has safety device ❑ Other _____ TRANSFER ❑ Self transfer ❑ 1 staff assist ❑ 2 or more staff assist ❑ Lift assist ❑ Other _____		

This Section Continued on Page 4

Functional Abilities, Supports/Nursing Issues
(Continued from Page 3)

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
POSITIONING ❑ Positions self ❑ Requires turning ❑ Requires positioning devices ❑ Uses "special" chair ❑ Other _____ BODY/SKIN CARE ❑ Skin tears easily ❑ Develops decubitus easily ❑ Dry skin ❑ Rashes ❑ Scaly scalp ❑ "Horny" toenails ❑ Has decubutus currently ❑ Has skin tears currently ❑ Other _____ HYGIENE ❑ Edentulous/no dentures ❑ Needs denture care ❑ Needs assist with grooming hair ❑ Brushes own teeth ❑ Needs staff assist ❑ Has beard ❑ Requires shaving assist ❑ Wears dentures ❑ Loses dentures frequently ❑ Other _____ DRESSING ❑ Dresses self with set up ❑ Needs 1 staff assist ❑ Needs 2 or more staff assist ❑ Wears "hip protectors" ❑ Wears Ted Hose ❑ Removes clothes ❑ Needs extra sweater/shirt ❑ Other _____ BATHING ❑ Prefers shower ❑ Prefers bathing ❑ Fearful of and/or hates water ❑ Requires 1 staff assist ❑ Requires 2 or 3 staff assist ❑ Prefers AM time ❑ Prefers PM time ❑ Prefers not to bathe ❑ Other _____		

This Section Continued on Page 5

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
SLEEPING ❑ Wanders at night ❑ Refuses to go to bed ❑ Sleeps in daytime ❑ Wakes up in middle of night ❑ Climbs out of bed ❑ Climbs over side rails ❑ Requires low bed ❑ Very confused when awakes ❑ Combative when awakes ❑ Does better when "sleeps in" ❑ Requires safety belt while in bed ❑ Other _____ EATING ❑ Needs to be fed ❑ Needs food cut up ❑ Uses special assistive foodware ❑ Needs special diet ❑ Drinks thickened liquids only ❑ Drinks liquids excessively ❑ Tube feeding ❑ Needs to be monitored for choking ❑ Needs to be monitored for taking others' food ❑ Other _____		

Substance Abuse Issues: Check (✓) only if this is a problem area. Provide detailed information regarding past and current abuse of substances. Please identify the severity of these issues, early warning signs, specific examples of the abuse, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
❑ Illegal substances history ❑ Alcohol history ❑ Other _____		

List the medical conditions. Provide detailed information regarding past and present treatments. Describe patient's responses to pain management if applicable.

Medical Conditions	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
Axis III Dx/NANDA Nursing Dx • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ • _____ Specialized Medical Supplies • _____ • _____ • _____ • _____		

Medication: Check (✓) only if this is a problem area. Describe how medications are administered and specific strategies used. Describe cause of prn usage if applicable.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
❑ Medication compliant ❑ Occasionally refuses ❑ Requires crushed medications ❑ Refuses frequently ❑ Spits medications out ❑ Will often take after 2nd/3rd offer ❑ Administers own medication with cues ❑ Requires prn use ❑ Other _____		

Individualized Needs: Check (✓) only if this is a problem area. Describe unique preferences or cultural needs that impact the patient's ability to function successfully. Include any area that would be important in supporting this person which is not addressed in other sections.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy/Accommodation
❑ Hobbies/activities		
❑ Comfort items		
❑ Natural supports		
❑ Cultural needs		
❑ Unique preferences		
❑ Significant dates		
❑ Smoking		
❑ Other _____		

Expanded Community Services
APU/PALS Discharge Assessment Form
May 24, 2002

This form must be completed at least 7 days before discharge of an ECS patient. In order to assist in the successful placement of patients with significant barriers to discharge please fill out this form as completely as possible. This form will be used to orient the staff of the receiving facility. It will additionally identify accommodations that need to be made for the patient to improve success in community placement.

Patient Name: _____

Name of persons completing form and contact information:

_____

_____

Aggressive Behaviors: Provide detailed information regarding past and recent aggressive behaviors. Please identify the severity of these issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy / Accommodation
• Assaultive Behaviors Yes ☐ No ☐ • Verbal Abuse Yes ☐ No ☐ • Impulse Control Yes ☐ No ☐ • Anger Management Yes ☐ No ☐ • Suicide History Yes ☐ No ☐ • Homicidal Ideation or Behavior Yes ☐ No ☐ • Property Damage Yes ☐ No ☐ • Self Mutilation or Other Harm to Self Yes ☐ No ☐ • Arson Yes ☐ No ☐ • Other Behaviors which are a Danger to Self or Others: _____ _____		

Interpersonal Skills & Cohabitation Issues: Provide detailed information regarding challenges with interpersonal skills or behaviors which provide challenges for living with others. Please identify the severity of these issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy / Accommodation
• Rummaging Through/ Taking Others Belongings Yes ☐ No ☐ • Sexual Acting Out Yes ☐ No ☐ • Preying on Vulnerable Others Yes ☐ No ☐ • Exposing or Disrobing in Public Yes ☐ No ☐ • Victimized by Others Yes ☐ No ☐ • Combativeness During Personal Care Yes ☐ No ☐ • Periods of Screaming or Inconsolability Yes ☐ No ☐ • Self Mutilation or Other Harm to Self Yes ☐ No ☐ • Non-Responsive to Emergencies Yes ☐ No ☐ • Wandering Yes ☐ No ☐ • Other _____		

Mental Status Issues: Provide information that may be helpful in addition to the diagnosis and medication lists that are provided. Please identify the severity of these issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy / Accommodation
• Impaired Judgement Yes ☐ No ☐ • Memory Impairment Yes ☐ No ☐ • Hallucinations Yes ☐ No ☐ • Delusions Yes ☐ No ☐ • Communication Issues Yes ☐ No ☐ • Other _____ _____		

Issues Related to Mood: Provide information that may be helpful in addition to the diagnosis and medication lists that are provided. Please identify the severity of these issues, early warning signs, specific examples of the behaviors, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy / Accommodation
• Depression/Sadness Yes ☐ No ☐ • Withdrawn Yes ☐ No ☐ • Motivation Yes ☐ No ☐ • Mood Lability Yes ☐ No ☐ • Anxiety Yes ☐ No ☐ • Reaction to Stress Yes ☐ No ☐ • Other _____		

Functional Abilities and Supports: Provide detailed information regarding functional abilities which provide challenges. Identify the severity of these issues, specific examples, and strategies for successfully accommodating or managing these issues.

Issue	Level of Severity and Examples	Strategy / Accommodation
• Toileting Yes ☐ No ☐ • Ambulation Yes ☐ No ☐ • Transfer Yes ☐ No ☐ • Positioning Yes ☐ No ☐ • Body Care Yes ☐ No ☐ • Hygiene Yes ☐ No ☐ • Dressing Yes ☐ No ☐ • Bathing Yes ☐ No ☐ • Sleeping Yes ☐ No ☐ • Eating Yes ☐ No ☐ • Food Preparation/ Preferences Yes ☐ No ☐ • Laundry/housework Yes ☐ No ☐ • Other _____ _____		

Substance Abuse Issues: Provide detailed information regarding past and current abuse of substances. Please identify the severity of these issues, early warning signs, specific examples of the abuse, and strategies for successfully accommodating or managing these behaviors.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy / Accommodation
• Illegal substances Yes ☐ No ☐ • Alcohol Yes ☐ No ☐ • Caffeine Yes ☐ No ☐ • Medications Yes ☐ No ☐ • Other _____ _____		

Medication and Medical Issues: Describe the patients ability to self medicate, response to pain, chronic medical conditions, recent medical procedures, and information on how medications are administered /monitored, and needed specialized medical supplies.

Issue	Level of Severity, Examples and Early Warning Signs	Strategy / Accommodation
• Medication Yes ☐ No ☐ • Medical Conditions Yes ☐ No ☐ • Specialized Medical Supplies Yes ☐ No ☐ • Other _____		

Individualized Needs: : Describe unique preferences or cultural needs that impact the patient's ability to function successfully. Include any area that would be important in supporting this person which is not addressed in other sections.

Issue	Description
• Hobbies/Activities Yes ☐ No ☐ • Comfort Items Yes ☐ No ☐ • Natural Supports Yes ☐ No ☐ • Cultural Needs Yes ☐ No ☐ • Unique Preferences Yes ☐ No ☐ • Significant Dates Yes ☐ No ☐ • Other _____	

Expanding Community Services
TRANSITIONAL TEAM GUIDELINES
JANUARY 30, 2002

AN INTEGRATED APPROACH TO PROVIDING SUCCESSFUL TRANSITION & COMMUNITY PLACEMENT

Transitional Team Guiding Principles:

- Creation of a client specific multidisciplinary transition team to:
  - establish minimum transition team membership
  - develop timeline for planning, discharge, transition & stabilization efforts

- Development of a coordinated, pre-discharge, wrap-around service plan to:
  - jointly develop a comprehensive Crisis Plan & associated risk assessment
  - identify available crisis services available in discharge area
  - develop a "transitional treatment plan" w/ consumer & staff input
  - identify natural, community & system supports available
  - WSH psychiatrists agree to discharge w/ meds *and* prescriptions to cover a minimum 14 day period following discharge
  - determine potential *flashpoint* events & timeline (ie missed med appointment)

- Delivery of intensive community support services following discharge
  - establish best practices regarding minimum "plus" expectations of service

Stakeholders:

Extensive stakeholder involvement, once discharge appropriateness has been determined, is crucial to the development and implementation of a plan that will follow the individual out of the hospital. The role of the stakeholders within the ECS process essentially requires that participants are willing to actively support an individual in his/her discharge, understanding that readmission to WSH is unlikely

Stakeholders should, in addition to the consumer, include such participants as:

- Mental health liaisons & case managers
- WSH staff
  - social workers
  - psychiatrists
  - nursing
- RSN representatives
- Crisis services
  - crisis triage center
  - agency crisis services
  - CDMHPs

- Family/friends identified by consumer
  - including clergy, friends, etc
- Residential providers
  - RSN contracted providers
  -boarding homes, adult family homes, nursing facilities
- Client advocates
- Ombuds services
  - mental health
  - Long Term Care
- Residential Care Services to assist with resident rights
- Home & Community Services
- Public Safety
  - DOC
  - Local law enforcement
- Chemical dependency professional if applicable

Pre-discharge Engagement Guidelines

Transition teams, containing some number of stakeholders identified above, will initiate the development of a coordinated engagement plan:

- Requires active consumer participation
- Identify peer advocate to participate in team
- Establish team facilitator w/ consumer input
- Identify specific RSN staff for involvement
- Assign clinical case manager from mental health agency
  - initiate pre-discharge meetings 2-3 months prior to D/C
  - first post-discharge appointment date established
- Identify WSH staff contact for pre/post discharge involvement
- Establish means to facilitate several assisted community visits with CM or SW

Pre-discharge Checklist

- Medicaid application completed, submitted & approved prior to DC
- Complete discharge packet for residential facility to include at least the following:
  - current psych eval & prog notes
  - challenging behaviors form
  - environment of care needs assessment including:
    - ✳ techniques
    - ✳ staff training
    - ✳ special accommodations
    - ✳ adaptive devices (WCs, doors, ramps, showers, beds, etc.)
    - ✳ personal &/or unique comfort items
- Medication coordination
  - initial psych med appointment with MH prescriber set by CM w/in 2 wks of DC
  - initial appointment with PCP w/in 3 weeks of DC
  - WSH psychiatrist D/C w/ 2 week supply meds
  - coordination with identified pharmacy for any specialty packaging of meds

- Schedule Comprehensive Assessment
  - HCS to conduct "first earliest" for medicaid eligible consumers
  - HCS to provide pre-discharge assessment update if necessary
  - Independent assessment for non-medicaid consumers
    - ✳ WSH SW to conduct or arrange for "independent" assessment
  - HCS to arrange for in-home services if applicable
- Create Comprehensive Crisis Plan:
  - identify strengths using client voice
  - establish specific interventions to address escalating/crisis behaviors
  - clarify conditions requiring "Alert" status w/ crisis services & area hospitals
  - outline inpatient re-admission criteria & location to non-WSH facility when possible
  - initiate Advanced Mental Health Directive
  - coordinate w/ WSH need for & conditions of LRA
  - provide plan to area hospitals, PCP, crisis services & residential provider
  - alert notification to Crisis Services of 24 hours prior to D/C & placement
- Develop Integrated Treatment Plan
  - minimum post-discharge service expectations
    - ✳ CM to transport consumer to new residential setting
    - ✳ Clt to be seen min. 2Xs at facility during 1st week
    - ✳ CM to see clt min. 1X / week during weeks 2-4
    - ✳ CM to consult with facility staff minimum 2Xs each week for 3 weeks
    - ✳ CM to see clt w/in 24 hr. of call by facility if escalation criteria are met
  - CM to transport consumer to all psych/med appointments during first 30 days
  - RSN & Clt develop "after hours" strategy for non-crisis escalation criteria
    - ✳ timeouts
    - ✳ behavioral interventions
    - ✳ "safe" contacts for Clt.
- Complete protective payee services, contacting SSA if necessary
- Facilitate selection of and visits to potential residential facilities
  - Discharge packet supplied to selected facilities after initial visits.

WESTERN STATE HOSPITAL
CONSUMER HOUSING-PREFERENCES SURVEY
EXECUTIVE SUMMARY

September 2002

Prepared by:

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EXECUTIVE SUMMARY

The Mental Health Division (MHD) of the Washington State Department of Social and Health Services, together with the Expanding Community Services (ECS) committee, requested a survey of housing preferences of mental health consumers who were eligible for discharge from Western State Hospital (WSH). The Washington Institute for Mental Illness Research and Training (WIMIRT) was asked to conduct the survey.

The survey's intent was to describe housing preferences of consumers who are eligible for discharge. The survey addressed three primary questions:

1. What do consumers need and/or want in housing situations that would enable them to remain in living situations outside of WSH?
2. What do consumers need and/or want to avoid in housing situations so that they may continue living in situations outside of WSH?
3. How realistic are consumers' expectations for living situations outside of WSH?

On March 25, 2002, the MHD forwarded to WIMIRT a list of 202 consumers residing at Western State Hospital who were potential candidates for ECS. These consumers had a significant history of long-term hospital placement, failed community placements, and significant barriers to placement in the community.

Data were gathered through face-to-face interviews on hospital wards. Data collection began in April 2002 was completed in early June 2002. Out of the 202 names on the contact list, 106 (52%) were contacted; 96 (48%) were not contacted, 72 (36%) participated in the survey while 34 (17%) refused.

The majority of respondents (79%) were under age 55. Eighty-one percent had a Global Assessment of Functioning (GAF) below 40. This range denotes serious mental and behavioral health symptoms and functional impairments. Fifty-six percent had not finished high school. Fifty-one percent had been in the hospital for 2 or more years. Thirty-eight percent had a history of Alcohol abuse and 41% had a history of drug abuse.

The majority of consumers in the survey lived alone or with family members prior to admission to Western State Hospital (39.7% and 39.7% respectively). A small percentage lived in group and boarding homes (19.1%), and none reported living in assisted living facilities prior to hospital admission.

Most consumers reported needing little assistance in daily living tasks. However, some reported needing assistance with doing laundry (a lot - 22.1%), preparing food (a little - 26.5%), and taking medications (a little – 26.9%).

Housing Preference Results:

- Sixty percent of consumers wanted medical/mental health staff to be available at least weekly.

- Most consumers surveyed were willing to live with another person (79.7%). Most consumers were willing to live with a room-mate (82.1%), followed by family members (66%), and lastly other individuals with mental health problems (63.2).

- The ability to smoke was an important factor for 63.7% of the consumers surveyed. Most wanted to be able to smoke outside (86.4%).

- Most consumers surveyed preferred to live in an apartment (37.3%) or private home (28.4%). Most consumers did not want to live in a nursing home or assisted living facility (60.3%).

- The majority of consumers surveyed wished to receive job training and placement services (70.3%), and had a desire to be employed (70.8%).

- A little over half of the consumers surveyed reported some difficulty managing their finances (54.1%). Over half reported a preference for assistance in managing their finances (51.6%).

- Most consumers surveyed felt that it was important to have access to a refrigerator (92.2%) and to be able to prepare meals (89.7%). The majority wanted to limit access to liquor stores and other places to purchase alcohol (46.9%).

- Most consumers surveyed thought that they would access public transportation a great deal (67.8% more than once a week).

- Most consumers surveyed felt it was important to have close access to religious services (73.4%).

- The most important entertainment and recreation activities rated by consumers were: having an individual phone (88.9%), a stereo (88.9%), a place nearby to go shopping (87.1%), an opportunity to go somewhere for coffee (85.7%), a television (79.4%), and a city park nearby (77.4%).

Expanded Community Services
Status Report of Consumers Served With Phase 2 Funding
October 3, 2002

ECS Funded Consumer	Current Placement	Current Status
Thurston1	Consumer lives in an extremely supportive adult family home in Thurston County that has been able to accommodate her increasing behavior problems which result from her advancing Huntington's Chorea. Enhanced services include an enhanced daily rate at the AFH to provide additional staffing for her extensive needs including frequent wakefulness during the night and uncontrolled outbursts during the day. Client is also attending an adult day health program. Client meets regularly with a psychiatrist, is receiving intensive case management support as well as ongoing medication management. A home mental health nurse has provided training to the AFH staff on the use of psychiatric medications.	Consumer's family is extremely happy with this placement. Client continues to face challenges based on the significance of her disability and continued increase in symptoms may require readmission to WSH or placement in a more specialized facility.
Thurston2	Consumer lives in a medically oriented adult family home in Thurston County. Enhanced services include an enhanced daily rate at the AFH to assist in managing his psychiatric issues and a very difficult to manage diabetic condition. He receives ongoing active mental health services including on site intensive case management and support from a psychiatrist. Consumer participates in an adult day health program.	Consumer has expressed his happiness with his community placement to his case manager on several occasions. He has become appropriately involved in the community such as visiting the library, participating in adult day health, lunching with his housemates, and actively participating with his church..

ECS Funded Consumer	Current Placement	Current Status
Thurston 3	Consumer lives in one-bedroom apartment in an intensive supportive living program in Thurston County which provides on site daily mental health supports. Client also receives on site intensive case management and assistance with community integration. Meets with a psychiatrist and receives ongoing medication management.	Consumer is adjusting well to her new home. She has become involved with her church and other social activities. Consumer has reconnected with her mother and adult children who were not in contact with her at WSH. Although apprehensive and initially resistant to leaving WSH, she now appears very content.
Thurston 4	Consumer lives in a one-bedroom apartment in intensive supportive living program in Thurston County which provides on site daily mental health supports. He also receives on site intensive case management and assistance with community integration. He with a psychiatrist and receives ongoing medication management. Much work is being done to assist in re-orienting this consumer to the community.	Consumer is adjusting well to new home. He reports this is the best living situation he has ever had. Consumer is interacting and socializing with neighbors in the apartment building.
Thurston 5	Consumer lives in a five-bedroom house with intensive supported living resources in Thurston County staffed 24 hours seven days a week. Consumer receives intensive case management, ongoing medication management and psychiatrist services. Mental health training has been provided to staff at the house. Long term plans include a focus on more independent community living and support of vocational efforts.	Consumer has had two short term hospitalizations in the community since the placement. Currently she is doing fine and is better taking care of her self. She interacts well and socializes with her housemates.
Thurston 6	Consumer lives in a five-bedroom house with intensive supported living resources in Thurston County staffed 24 hours 7 days a week. Consumer receives intensive case management and ongoing medication management. Mental health training has been provided to staff at the house. Long term plans include a focus on more independent community living and support of vocational efforts.	Consumer is doing well but is having some challenges with medication compliance. Her family has been very involved and are supportive of the placement.

ECS Funded Consumer	Current Placement	Current Status
Timberlands 1	Consumer lives independently in a trailer in Pacific County with support of in-home personal care services including but not limited to, laundry, housekeeping, meal planning and preparation. Other supports are provided through mental health intensive case management services on a 24/7 basis. These are provided on at least a twice a day basis, seven days a week and include medication monitoring, individualized tailored care plan implementation, shopping, outings, and other activities designed to prevent isolation and provide for consumer needs as defined in his Individualized Care Plan.	Consumer is very pleased to be out of the hospital and has been totally compliant with court mandated discharge conditions. He is showing considerable initiative in complying with the plan. Client is somewhat anxious in the community and welcomes case management support.
North Sound 1	Consumer lives in one of two three-bedroom private homes adjacent to each other with intensive 24-hour supervision in Snohomish County. Specific additional staff have been hired in all three programs to provide these highly intense services. All consumers in this program are receiving services 7 day a week and receive comprehensive mental health services including case management, medication management, and psychiatric nursing and have access to a psychiatrist as needed. In addition to these services, this consumer also receives day treatment.	Consumer has adjusted very well. In the hospital, contact had been cut off between consumer and the family. He has reestablished contact with family and visits each weekend. Consumer previously had long history of substance abuse but has not had occurrence since his placement.

ECS Funded Consumer	Current Placement	Current Status
North Sound 2	Consumer lives in one of two three-bedroom private homes adjacent to each other with intensive 24-hour supervision in Snohomish County. Specific additional staff have been hired in all three programs to provide these highly intense services. All consumers in this program are receiving services 7 day a week and receive comprehensive mental health services including case management, medication management, and psychiatric nursing and have access to a psychiatrist as needed. In addition to these services, this consumer also participates in drop in center activities..	Consumer has adjusted very well. Consumer had a long prior history of leaving placements and becoming assaultive. He is doing very well in this placement. Community staff who know this individual say he is doing better than he ever had previously. He participates in social activities through a local drop in center.
North Sound 3	Consumer lives in one of two three-bedroom private homes adjacent to each other with intensive 24-hour supervision in Snohomish County. Specific additional staff have been hired in all three programs to provide these highly intense services. All consumers in this program are receiving services 7 day a week and receive comprehensive mental health services including case management, medication management, and psychiatric nursing and have access to a psychiatrist as needed.	Consumer has adjusted very well. He had some challenges regarding cooperation with coordination efforts to establish financial benefits. Significant effort has been made toward establishing a guardian. At WSH, consumer refused to communicate with family members. He has reconnected with family and is having regular contact and visits.
North Sound 4	Consumer lives in one of two three-bedroom private homes adjacent to each other with intensive 24-hour supervision in Snohomish County. Specific additional staff have been hired in all three programs to provide these highly intense services. All consumers in this program are receiving services 7 day a week and receive comprehensive mental health services including case management, medication management, and psychiatric nursing and have access to a psychiatrist as needed. In addition to these services, this consumer also receives co-occurring substance abuse services and participates in drop in center activities.	Consumer has had some challenges in community placement. He had one very brief re-hospitalization at WSH and had 3 short term hospitalizations at a local psychiatric evaluation and treatment center. He is currently back in the setting and staff report he is doing very well. Consumer had long extensive history of alcohol abuse but has not used since ECS placement in the community. He participates in social activities through a local drop in center.

ECS Funded Consumer	Current Placement	Current Status
North Sound 5	Consumer lived in one of two three-bedroom private homes adjacent to each other with intensive 24-hour supervision in Snohomish County. Specific additional staff have been hired in all three programs to provide these highly intense services. All consumers in this program are receiving services 7 day a week and receive comprehensive mental health services including case management, medication management, and psychiatric nursing and have access to a psychiatrist as needed.	Tragically, this consumer died from complications related to a non mental health related medical condition. Consumer had seizure disorder which he was taking medications for. The medications were not completely effective and he periodically had seizures prior to and after his discharge. After a seizure in the community, he was taken to the hospital and lapsed into a coma. At the hospital, he developed an antibiotic resistant respiratory infection. He was moved to a Nursing Home and passed away from complications resulting from these conditions. Prior to his death, consumer was doing very well and was re-integrating with community living. He expressed happiness with his return to the community and his father was supportive and positive regarding placement.
North Sound 6	Consumer lives in one of two three-bedroom private homes adjacent to each other with intensive 24-hour supervision in Snohomish County. Specific additional staff have been hired in all three programs to provide these highly intense services. All consumers in this program are receiving services 7 day a week and receive comprehensive mental health services including case management, medication management, and psychiatric nursing and have access to a psychiatrist as needed.	This consumer has recently filled the slot of the individual who passed away as mentioned above. He is doing very well and has met with his Mother on a number of occasions. He participates in social activities at the local drop in center and is re-acclimating to community living. Consumer gets along well and socializes with his house mates.

ECS Funded Consumer	Current Placement	Current Status
North Sound 7	Consumer lives in one of two three-bedroom private homes adjacent to each other with intensive 24-hour supervision in Snohomish County. Specific additional staff have been hired in all three programs to provide these highly intense services. All consumers in this program are receiving services 7 day a week and receive comprehensive mental health services including case management, medication management, and psychiatric nursing and have access to a psychiatrist as needed. Staff have supported consumer in frequent visits to WSH to maintain relationships with staff and patients who he had become attached to during his long hospital stay.	Consumer has had some challenges with adjustment. Because of his long history, he had become very attached to staff and patients at WSH. Staff from the community program have taken him for frequent visits to ease the transition. In addition, the consumer's mother recently passed away creating additional stress. Consumer is beginning to search for old friends and reconnected with family he had not seen for 25 years at his mother's funeral. Consumer has expressed an interest in moving from this intensively staffed program to his own apartment in the intensive case management ECS program in Bellingham.
North Sound 8	Consumer receives support from an intensive 7-day-a-week case management program for four people in Whatcom County. Each receives medication management through regular visits with a psychiatrist. A team approach and extra staffing is used to provide highly intense individualized services 7 days a week . An occupational therapist will be used to assist with vocational efforts and job supports once consumer becomes employed.	Consumer has had challenges in the community. He has been re-hospitalized at WSH and has not stabilized sufficiently to be placed back in the community as of yet. He is doing better and plans are to place him back in the community in the next 2-4 weeks.
North Sound 9	Consumer receives support from an intensive 7-day-a-week case management program for four people in Whatcom County. Each receives medication management through regular visits with a psychiatrist. A team approach and extra staffing is used to provide highly intense individualized services 7 days a week . An occupational therapist will be used to assist with vocational efforts and job supports once consumer becomes employed.	Consumer was hospitalized briefly at WSH and has returned to community living. He currently is doing very well. He is connected with his family who he sees regularly. The family is exploring the possibility of providing him a job in a shop run by his brother. He recently obtained a bike and is using it to get around Bellingham.

ECS Funded Consumer	Current Placement	Current Status
North Sound 10	Consumer receives support from an intensive 7-day-a-week case management program for four people in Whatcom County. Each receives medication management through regular visits with a psychiatrist. A team approach and extra staffing is used to provide highly intense individualized services 7 days a week . An occupational therapist will be used to assist with vocational efforts and job supports once consumer becomes employed.	Consumer is doing very well. He has been connected with DVR and is in the process of vocational assessment.
North Sound 11	Consumer receives support from an intensive 7-day-a-week case management program for four people in Whatcom County. Each receives medication management through regular visits with a psychiatrist. A team approach and extra staffing is used to provide highly intense individualized services 7 days a week . An occupational therapist will be used to assist with vocational efforts and job supports once consumer becomes employed.	Consumer is doing very well and is working toward employment goals. His mental health symptoms are stable.
North Sound 12	Consumer lives in an intensely staffed and supported adult family home in Skagit County. Specific additional staff have been hired in the AFH to provide highly intense services. She is receiving comprehensive mental health services weekly including case management, medication management, and access to a psychiatrist, and is involved with groups at the local agency.	Consumer is doing well. Consumer has frequent contact with mother who takes for regular shopping and social activities. She actively participates in groups and has obtained a computer which she plans to use to write her memoirs. Staff at AFH say she has adjusted very well.

ECS Funded Consumer	Current Placement	Current Status
North Sound 13	Consumer lives in an intensely staffed and supported adult family home in Skagit County. Specific additional staff have been hired in the AFH to provide highly intense services. She is receiving comprehensive mental health services weekly including case management, medication management, and access to a psychiatrist, and is involved with groups at the local agency.	Consumer is involved in regular groups at the day center. She has contact with her father and is seeing him. She has an ongoing relationship with a boyfriend who has been abusive in the past. Community staff have supervised visits with this boyfriend so that she can visit him while remaining safe. Consumer is looking for work and has gone on some job interviews.
North Sound 14	Consumer lives in his own apartment which is located in a crisis respite home so he has access to 24 hour intensive mental health services. He receives case management, medication management and has regular visits with a psychiatrist. Staff are working to assist consumer with independent living skills as he has been institutionalized for over 30 years. Staff have also worked to assist consumer with good eating habits as he has been chronically underweight.	Consumer reports he is doing very well and states that he is very happy with his community placement. He likes the community so well he is volunteering to pick-up litter on the streets and beaches. He had been chronically underweight, even at WSH, but has now gained 10 pounds since his placement.
Peninsula 1	Consumer is living in his own apartment in Forks where he receives comprehensive community support including day treatment, medication management, and individualized community support. The consumer participates in day treatment 7 days/week and has evening community support for three hours each day. In addition, he receives individual therapy weekly and psychiatric medication management as prescribed. Individual case management services to assist with daily living needs and skill building occur on a regular basis.	Consumer remains stable, although reality testing is compromised by paranoid ideation. He is cooperating with his treatment plan and participates in day treatment activities.

ECS Funded Consumer	Current Placement	Current Status
Peninsula 2	Consumer was initially discharged from WSH and spent several weeks in the Crisis Stabilization Unit to assess his needs. He now lives in an independent apartment in Bremerton with supports. Services are provided five times a week to teach cooking and basic house maintenance skills. Consumer receives services from a case aide 7 days a week to assist with community integration activities. These activities emphasize healthy living habits as well as benefits of being employed and living a productive life. Consumer has regular visits with his case-manager, monthly doctor appointments, and visits to a provider in the community with expertise in psycho-sexual educational and treatment.	Consumer is doing well and staff are pleased with results obtained so far. He is following his treatment regimen and appears to be greatly benefiting from the treatment plan he helped create. He has had a lot of contact with family which in this case has had some negative effects. Community support staff are working to engage the family and help them understanding how they can be helpful in more productive ways.
Peninsula 3	Consumer resides in a mental health residential treatment facility in Bremerton County providing staff an opportunity to assess her current needs. The facility offers her a structured environment and extra staff resources that were put in place help her develop a daily routine that contributes to her stability. Clinical and nursing staff spent considerable time teaching the consumer how to manage her diabetes. The nurse at the facility procured a blood sugar measuring device that is very user friendly. Nursing staff continues to play an active role in educating her about her medical condition. Long term plans are to find her an independent apartment providing resources to meet her individual needs at that time.	Consumer was placed – with her input – on a behavioral plan that appears to be working very well. She participates in day treatment and is also perfecting her cooking skills and contributing to the milieu by doing some of the necessary household chores. Consumer is learning to monitor her diabetes and nursing staff are pleased with the results obtained so far.

ECS Funded Consumer	Current Placement	Current Status
Peninsula 4	Consumer is living independently in Port Angeles. He receives supervised medication monitoring, intensive case management services and ongoing doctor's appointments. Consumer receives support for social , recreational, and work activities.	Consumer has been doing very well in all aspects of his treatment. He. has complied with taking his medications, and follows his treatment plan. He has also complied with court ordered discharge requirements. He has become involved in recreational activities, and has even worked a few days for a local moving company. Currently, educational goals are being developed. Consumer is in contact with his family.
Peninsula 5	Consumer was initially placed at a licensed boarding home, but was relocated to transitional housing in Port Angeles where he receives medication monitoring services twice daily since his arrival. He receives comprehensive intensive case management supports with contacts several times a day. Staff is working to support him in addressing his physical health issues.	Consumer is doing well in his current placement but has been only marginally cooperative with efforts to manage some of his other health problems. It has been difficult to get him involved in social and recreational activities. Currently the goal is to continue to address health issues and keep him engaged.

ECS Funded Consumer	Current Placement	Current Status
Peninsula 6	Consumer lives in housing in Port Townsend which is safe, permanent, appropriate and away from taverns per the consumer's request. He receives intensive case management services to monitor his medications and his activities of daily living. He participates in day treatment activities to promote pro-social and appropriate social skills and received additional daily support from a case aide. Due to isolative qualities and past history with alcohol abuse, support has been provided for healthy social/recreational goals.	Consumer is doing well. He participates in day treatment and is attending educational classes. He has obtained a computer and bus pass.
Clark 1	Consumer is living in an Adult Family Home (AFH) in Pierce County where his guardian lives. He has cognitive issues which effect his functioning and the AFH has specialty in serving persons with cognitive issues. They provide 24-7 support for his personal care needs. He receives ongoing services from a psychiatrist and medication management. A case manager working for the consumer's guardian visits the consumer weekly to make sure his needs are met and engages him in community integration (e.g. shopping, going to restaurants). Support has been provided to the AFH and guardian to assure all of the consumers needs can be met.	Consumer was initially placed in another AFH but moved to one which has more specialty in serving persons with cognitive issues. Consumer is doing very well in this placement. Consumer's guardian is very pleased and supportive of the placement. Consumer is reintegrating into community activities.

ECS Funded Consumer	Current Placement	Current Status
Clark 2	Consumer is living in a Congregate Care Facility in Ridgefield WA. This facility was funded to hire additional staff to support consumer's serious medical and behavioral needs. Chore services have been provided to assist consumer with activities of daily living. Consumer is served by PACT Team which provides intensive mental health treatment. The team includes a psychiatrist, case manager, and registered nurse and most services are provided on site at the CCF. Consumer is visited almost daily by team members and services are available seven days a week, 24 hours a day.	Consumer was initially placed in another facility which was not able to meet her needs despite additional supports. She has had some issues in her new CCF placement resulting from difficulty in engagement and aggressive behaviors with other residents and caregivers. Over the past few weeks, she has shown progress in this area and is working toward the goal of returning home to live with her husband.
Clark 3.	Consumer is living in a mental health residential treatment facility in Vancouver which provides supervision 24 hours a day, seven days a week for assistance with daily living and comprehensive mental health needs including case management, medication management, nursing and psychiatrist services provided on site.	Consumer has done well at ARRC and RSN is working toward long term placement. She is engaged in treatment and participating regularly in group activities. Consumer has good family support who visit her regularly and are happy with her placement.